

# U.S. NAVY MEDICINE

May 1978



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**COVER:** LT Maureen F. Clary (USNR) is one of more than 2,500 Navy nurses who will be celebrating the Nurse Corps' 70th anniversary this month. Nominated by her command for recognition as an outstanding representative of the Corps, she is currently assigned to the Neonatal Intensive Care Unit at NRMCC San Diego.

# From the Surgeon General

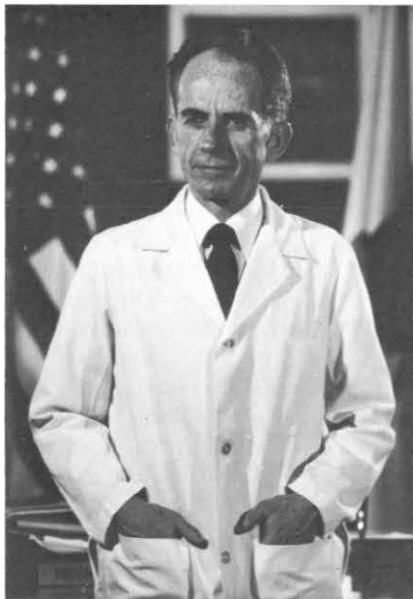
## Open Letter to Navy Nurses

Since its beginning 70 years ago, the Nurse Corps has been a vital element of the Navy health care team. The Corps' growth—not only in numbers, but in diversity and versatility—makes it a prime example of an organization that has evolved to meet the changing needs of the society it serves.

In these times it is imperative that we in the Medical Department utilize all our resources to the fullest, and the Nurse Corps officers of 1978 have more than risen to this challenge.

From an original nucleus of 20 nurses, the Corps has grown to more than 2,500 men and women, serving in a variety of assignments and dedicated to providing the highest quality of patient care. As this issue of **U.S. Navy Medicine** illustrates, Nurse Corps officers today are not only filling the more traditional nursing roles, but also are increasingly involved in educating patients and planning and providing patient care at all levels, including primary care. Current efforts to relieve Nurse Corps officers of the nonprofessional, administrative tasks with which they have been plagued in the recent past will enable these officers to use their talents more fully in the specialties for which they have been prepared.

In all Nurse Corps planning and action, changes in the demography of the Corps and changes within professional nursing itself must be considered. For example, of the approximately 2,500 Nurse Corps officers on active duty, 21.5% are male. It is imperative that these officers, now representing nearly one quar-



VADM Arentzen

ter of Corps strength, be fully utilized in all types of assignment.


These changes also affect other areas, such as education. DOD guidance provides that applicants with baccalaureate education are given priority for commission, and 64% of Nurse Corps officers currently hold a baccalaureate or higher degree in nursing. Since the quality of nursing care is directly related to the professional competence of nursing practitioners, continuing education is to be encouraged. The Navy Nurse Corps, with its Continuing Education Approval and Recognition Program, was the first federal nursing agency to gain American Nurses Association accreditation as an approver and provider of continuing education. This program will be used as a model for

other Corps within the Navy Medical Department.

Adequate staffing remains a problem. Although the Nurse Corps has remained at or near authorized strength during the past few years, the demand for professional nursing care continues to grow. I consider our number of authorized nursing billets to be inadequate: although we are now at authorized strength, we all recognize the need for additional Nurse Corps officers. This is a paradox to those who measure quality patient care only in terms of length of patient stay or daily patient load, and unfortunately it is this kind of quantifiable data that determines the allocation of defense money. Too seldom is it acknowledged that the patients remaining in our hospitals require specialized care and staffing patterns applicable to a now complicated and sophisticated environment.

I am aware of the frustrations confronting you. I am also aware of your accomplishments, and I sincerely thank you for your commitment to our patients and to the Navy Medical Department, despite the problems we all share in these difficult times.

As you enter another year of service, I wish for you continued growth and challenge in assuring first-rate health care for our Navy and Marine Corps family.

  
W.P. ARENTZEN  
Vice Admiral, Medical Corps  
United States Navy

# Seven Picked for Flag Rank

The Medical Department has seven new flag officers—five from the Medical Corps (three active-duty, two Reserve) and two from the Dental Corps (one active-duty, one Reserve).

RADM-selectee **Stephen Barchet** (MC), commanding officer of the Naval Health Sciences Education and Training Command, Bethesda, Md., since 1977, also holds the position of Special Assistant to the Surgeon General for Medical Department Education and Training.

Dr. Barchet was born 25 Oct 1932 in Annapolis, Md. He attended Brown University and completed medical school under Navy sponsorship, receiving his M.D. degree from the University of Maryland in 1956. His graduate medical education included general surgery at Naval Hospital Portsmouth, Va.; obstetrics and gynecology at Naval Hospital Boston; and a pathology fellowship at Harvard's Hospital for Women, Brookline, Mass.

Dr. Barchet has served as an obstetrician-gynecologist at Navy facilities in Naples, Italy; Portsmouth, N.H.; Beaufort, S.C.; and Bremerton, Wash. From 1966 to 1967, he was commander of MILPHAP Team #2, Quang Nam Province, South Vietnam, and from 1970 to 1973 he was chairman of obstetrics and gynecology at Naval Hospital Boston.

In 1973, Dr. Barchet joined the Bureau of Medicine and Surgery, serving first as assistant head, and later as head, of the Training Branch. In 1975 he became Deputy Special Assistant to the Surgeon General for Medical Department Education and Training and subsequently served for nine months as BUMED's physician representative

on the Chief of Naval Operations' Select Committee to Review Navy Health Care. From 1976 to 1977, he held appointments as associate dean of the Uniformed Services University of the Health Sciences School of Medicine and executive secretary of the USUHS Board of Regents.

Dr. Barchet is certified by the American Board of Obstetrics and Gynecology and holds medical school faculty appointments at Boston University and The George Washington University. He is a fellow of the American College of Obstetricians and Gynecologists, and his memberships include the International Society for the Study of Vulvar Diseases, Baker-Channing Society, American Medical Association, Association of Military Surgeons of the United States, and Society of Medical Consultants to the Armed Forces. He is also chairman of the Medical-Dental Committee of the Interservice Training Review Organization, alternate regent to the National Library of Medicine Board of Regents, and consultant to the National Board of Medical Examiners' Panel on Allied Health. He holds the Bronze Star (Combat V), Meritorious Service Medal, Meritorious Unit Commendation, Republic of Vietnam Meritorious Unit Citation, Republic of Vietnam Certificate of Merit (1966 and 1967), and Republic of Vietnam Ministry of Health Certificate of Appreciation.

RADM-selectee **John R. Lukas** (MC), commanding officer of Naval Regional Medical Center Corpus Christi since 1974, was born 24 Sep 1925 in Mercer, Pa. He entered the Navy under the V-12 program in

1943 and was commissioned an ensign in 1945. He subsequently completed flight training and was designated naval aviator in 1946. In 1947, he was granted early release from active duty and returned to school, receiving his B.S. degree in chemistry from Westminster College in 1950 and his M.D. degree from the University of Pittsburgh in 1954.

Commissioned a lieutenant (junior grade) in the Naval Reserve, Dr. Lukas served a rotating internship at Naval Hospital Oakland, followed by residency training in obstetrics and gynecology at the same hospital. In 1957 he was augmented



CAPTs Barchet and Lukas

into the Regular Navy, and in 1959—following instruction at the School of Aviation Medicine, Pensacola—he was designated a naval flight surgeon.

Dr. Lukas served for a year as medical officer at Naval Postgraduate School, Monterey, Calif., then was ordered to the USS *Lexington*. As medical officer, he participated in her last cruise as an attack carrier in the Western Pacific. Subsequently he served as assistant chief of the Ob/Gyn Service at Naval Hospital Oakland; as medical officer at Naval Air Stations Alameda, Calif., and Agana, Guam; and as base surgeon at Marine Corps Base Quantico, Va.



In 1971, he was ordered to Kenitra, Morocco, serving for two years as officer in charge of the station hospital and as aerospace medical consultant to the Royal Moroccan Air Force. In 1973 he became director of clinical services at Naval Hospital Corpus Christi.

Dr. Lukas is certified by the American Board of Obstetrics and Gynecology. He is a fellow of the American College of Obstetricians and Gynecologists and of the American College of Surgeons, and is a member of the Nueces County Medical Society, the American Medical Society, and the Aerospace Medical Association. He holds the American Campaign Medal, World War II Victory Medal, American Service Medal with star, Navy Unit Citation Medal, and Republic of Vietnam Meritorious Unit Citation Medal.



**CAPTs Museles and Senior**

RADM-selectee **Melvin Museles** (MC), commanding officer of Naval Regional Medical Center Jacksonville since 1976, was born 24 Oct 1929 in Boston, Mass. He graduated from Boston University in 1950 with a B.A. degree in chemistry, cum laude, and received his M.D. degree from Tufts University Medical School in 1954.

Dr. Museles began his military service in 1954 as an intern at Naval Hospital Boston, with the rank of lieutenant (junior grade). He received his residency training in pediatrics at the same institution and at Children's Hospital Medical Center, Boston.

Following a tour of duty at Naval Hospital Guantanamo Bay, Cuba, Dr. Museles entered civilian practice but returned to active duty after only nine months. From 1959 to 1962, he served as assistant chief of pediatrics at Naval Hospital Boston. Following tours as chairman of the Department of Pediatrics at Naval Hospital Portsmouth, Va. (1962-1967), and at Naval Hospital Bethesda (1967-1971), he was appointed assistant head of the Training Branch, Bureau of Medicine and Surgery, in 1971; then head of the Training Branch in 1972.

In July 1973, Dr. Museles was selected by the Secretary of Defense to serve as first executive secretary to the Board of Regents of the Uniformed Services University of the Health Sciences, and in 1974 he was appointed the first associate dean of the USUHS School of Medicine. In these capacities he played a leading role in initial development of the university and its relationships with military teaching hospitals.

Dr. Museles is certified by the American Board of Pediatrics and holds appointments as clinical professor of pediatrics at Georgetown University Medical School and as associate clinical professor of pediatrics at Howard University Medical School. He is a fellow of the American College of Physicians and the American Academy of Pediatrics, and was pediatrician to the White House during the Johnson Administration. He holds many other academic and administrative appointments, as well as memberships in national professional organizations. His military awards include the Legion of Merit, the Meritorious Service Medal, the Navy Commendation Medal, and the National Defense Medal with Bronze Star.

Naval Reserve RADM-selectee **John R. Senior** (MC) is commanding officer of Second Marine Division Medical Headquarters Detachment 104, West Trenton, N.J. He is director of the Special Treatment Unit for Alcohol-Related Disorders and director of the Office of Evaluation,

Graduate Hospital, University of Pennsylvania. He also is associate professor of medicine at the university's School of Medicine.

Dr. Senior was born 17 July 1927 in Germantown, Pa. He entered the Naval Reserve in 1945 and served as a seaman, first class, with the Naval Air Transport Service, Pacific. He received a B.S. degree in physics from Pennsylvania State University in 1950, was commissioned an ensign (HP) in 1951, and received his M.D. degree from the University of Pennsylvania in 1954. Following internship and residency training in medicine at the Hospital of the University of Pennsylvania, he spent three years as a research fellow in medicine at Massachusetts General Hospital and Harvard University.

From 1962 to 1971, he was director of the Gastrointestinal Research Laboratories at Philadelphia General Hospital, and from 1964 to 1970 he served as director of the training program in gastroenterology for the National Institute of Arthritis and Metabolic Diseases, NIH. He was project director of the Computer-Based Examination Project for Measurement of Competency in Medicine of the American Board of Internal Medicine (1970-1974), director of clinical investigation at Presbyterian-University of Pennsylvania Medical Center (1971-1973), and director of the Clinical Research Center, Graduate Hospital, University of Pennsylvania (1973-1974).

Since 1955, Dr. Senior has participated in the Ready Reserve, serving, among other assignments, as commanding officer, Philadelphia Medical Reserve Company Unit 4-3, and senior medical officer, Submarine Divisions, Naval Base Philadelphia. He was designated a submarine medical officer in 1971, and a saturation diving medical officer in 1977. He has been the Navy's medical school liaison officer at the University of Pennsylvania since 1966.

Dr. Senior is certified and recertified by the American Board of Internal Medicine and is certified by its Subspecialty Board on Gastroenterology. He is a consultant-lecturer

on gastroenterology for the Veterans Administration, and a consultant to the National Board of Medical Examiners and the American Board of Internal Medicine.

He is a fellow of the American College of Physicians and a member of the American Federation for Clinical Research, the American Gastroenterological Association, the American Association for the Study of Liver Diseases (past president, 1973-1974), the American Physiological Society, the American Society for Clinical Investigation, and the International Association for Study of the Liver. He holds the World War II Victory Medal, the Naval Reserve Medal, and the Armed Forces Medal.

Naval Reserve RADM-selectee **Park W. Willis III (MC)** is medical officer for NRPERSMOBTEAM 1713, Naval Reserve Center, Southfield, Mich., and professor of internal medicine in the Division of Cardiology at the University of Michigan Medical School.

Dr. Willis was born 18 Nov 1925 in Seattle, Wash. He entered the Navy under the V-12 program in 1943. In 1948 he received his M.D. degree from the University of Pennsylvania and was commissioned a lieutenant (junior grade) in the Naval Reserve. After completing a two-year rotating internship at Pennsylvania Hospital, Philadelphia, he was assigned as staff medical officer in internal medicine and cardiology at Naval Hospital Bethesda, Md., following which he was assigned as battalion and then regimental surgeon to the First Marine Division in Korea. In January 1952, he was ordered to Naval Hospital Bremerton, Wash., as staff medical officer in internal medicine and dermatology, and in September of that year he entered the residency training program in internal medicine at University Hospital, Ann Arbor, Mich.

Dr. Willis has participated in the Ready Reserve since 1952, and has remained at the University of Michigan since his residency, becoming

junior clinical instructor in internal medicine in 1953; instructor in internal medicine in 1954; assistant professor of internal medicine in 1956; associate professor in 1959; and full professor in 1965. He has been the Navy medical school liaison officer at the university since 1957.

Other responsibilities include appointments as a consultant in cardiology to the Navy Surgeon General; as a consultant-lecturer at Naval Hospital Bethesda; as a consultant in internal medicine to the Veterans Administration Hospital, Ann Arbor; and as consultant to the Wayne County General Hospital, Eloise, Mich.

Dr. Willis is certified by the American Board of Internal Medi-

cal Consultants to the Armed Forces. He is vice president of the Association of University Cardiologists and past president of the Michigan Heart Association and the Detroit Heart Club.

Dr. Willis holds the Presidential Unit Citation with star, the Naval Reserve Medal, the American Campaign Medal, the World War II Victory Medal, the National Defense Service Medal, the Korean Service Medal with four stars, the Armed Forces Reserve Medal, the United Nations Service Medal, and the Republic of Korea Presidential Unit Citation.

RADM-selectee **John B. Holmes (DC)**, commanding officer of Naval Regional Dental Center San Fran-



**CAPTs Willis, Holmes, and Anderson**

cine and its Subspecialty Board on Cardiovascular Disease. He is a fellow of the American College of Physicians and the American College of Cardiology, and is a member of the American Heart Association, a member of the AHA Council on Thrombosis, and a fellow of the AHA councils on Clinical Cardiology, Arteriosclerosis, and Epidemiology. Other memberships include the American Federation for Clinical Research, the American Association for the Advancement of Science, the International Society of Cardiology and its councils on Epidemiology and Atherosclerosis, the International Society on Thrombosis and Haemostasis, and the Society of

cisco, was born 20 Mar 1929 in Invermere, British Columbia. He received a B.S. degree in zoology from the University of Idaho in 1950, and in 1954 was awarded his D.D.S. degree by the University of Washington School of Dentistry. That same year, he began active duty at Naval Training Center San Diego as a lieutenant (junior grade).

Following duty at the Naval Postgraduate School in Monterey, Calif., Dr. Holmes was assigned as dental officer to the USS *Badoeng Strait* (CVE-116). He next served at Naval Station Treasure Island, San Francisco, then attended the General Postgraduate Course, Naval Dental School Bethesda, after which

he was assigned to the Second Marine Division, Fleet Marine Force, Atlantic.

Dr. Holmes completed residency training in prosthodontics at Naval Dental School Bethesda in 1963 and subsequently served as dental officer aboard the USS *Saratoga* (CVA-60). Following a tour of staff duty at the Naval Dental School, he reported to BUMED for duty as head, Appointment and Assignment Section, Dental Division. In 1974, he received his M.S. degree in education from The George Washington University and that same year became head of the Dental Division's Personnel Branch, going from that post to his current assignment.

Dr. Holmes is a diplomate of the American Board of Prosthodontics, an active fellow of the Academy of Denture Prosthetics, a charter fellow of the American College of Prosthodontics, a fellow of the American College of Dentists, and a fellow of the International College of Dentists. He holds the Navy Commendation Medal and the National Defense Service Medal with Bronze Star.

Naval Reserve RADM-selectee **Frank H. Anderson** (DC) is wing dental officer with the Fourth Marine Aircraft Wing, New Orleans, and has a private dental practice in Johnson City, Tenn.

Dr. Anderson was born on 27 Nov 1929 in Johnson City, Tenn. He received his B.S. degree from East Tennessee State University in 1950 and his D.D.S. degree from the University of Tennessee College of Dentistry in 1953. That same year he was commissioned a lieutenant (junior grade) and served on active duty until 1956, with tours at Great Lakes, Ill., and with the U.S. Naval Retraining Command in San Diego. Since then, as a member of the Ready Reserve, he has been affiliated with the Naval Reserve Center, Kingsport, Tenn.; the Naval Reserve Facility, Greenville, Tenn.; and the U.S. Navy Recruiting District, Nashville, Tenn. He has served as chairman of the Recruit-

ing District Assistance Council, Nashville District for Recruiting, and has been Tennessee coordinator of the U.S. Naval Academy Blue and Gold Program since 1970.

Dr. Anderson is a fellow of the Academy of General Dentistry and has been nominated for fellowship in the International College of Dentists. He is a member of the American Prosthodontic Society and the Southeastern Academy of Prosthodontics, a past president of the First District Dental Society, and an

alternate trustee to the Tennessee Dental Association. In 1976 he received the Tennessee Dental Association's Fellowship Award for professional service to dentistry.

Dr. Anderson is chairman of the Advisory Committee to the School of Dental Hygiene, East Tennessee State University, and co-chairman of the alumni fund drive for a new dental school building at the University of Tennessee. He holds the National Defense Service Ribbon and the Naval Reserve Medal.

## New MSC Chief

CAPT Paul D. Nelson (MSC) has been named seventh chief of the Navy Medical Service Corps. He will succeed CAPT William J. Green, Jr. (MSC), who will retire on 1 Jun 1978.

For the past year, CAPT Nelson has been director of manpower and facilities management at the Naval Medical Research and Development Command, Bethesda, Md. For three years prior to that, he was head of the Human Performance Division at the same command.

Born 20 Sep 1932 in Akron, Ohio, CAPT Nelson was commissioned an ensign in the Medical Service Corps in 1956. He subsequently served as a research psychologist at the Naval School of Aviation Medicine, Pensacola; as a staff psychologist with the Naval Air Advanced Training Staff, Corpus Christi; and as a research psychologist with the Navy Medical Neuropsychiatric Research Unit, San Diego. In 1966 he was appointed head of the Human Effectiveness Branch, Research Division, at BUMED, where he served until being transferred to the Naval Medical Research and Development Command in 1974.

CAPT Nelson graduated from Princeton University in 1954. He received a master's degree in psychology from the University of Chicago in 1955, and in 1961 was awarded his doctorate in psychology

from the same university. He holds a faculty appointment as associate professor (lecturer) in management science at The George Washington University, Washington, D.C., and is a member of the editorial staff of the *Journal of Armed Forces and Society*.

CAPT Nelson has been a member of the Navy Standing Committee on Personnel Training and Readiness, the DDR&E Behavioral Science Subcommittee, and the DDR&E Committee for Coordination of Research on Alcoholism and Drug Abuse. He also serves as executive chairman and U.S. national leader of the Technical Cooperation Program Action Group on Human Performance Research and Military Capability.

He is a fellow of the American Psychological Association and president of that association's Division of Military Psychology. He is also a fellow of the Inter-University Seminar on Armed Forces and Society and holds memberships in Sigma XI and the International Association of Applied Psychology.



**CAPT Nelson**



# Life Support Stretcher

The Navy has long had need of a life support stretcher that would permit uninterrupted care and monitoring of critically ill patients in transit. Now the prototype of such a stretcher—incorporating a number of life-support features—has been developed at the Naval Ocean Systems Center (NOSC), San Diego, under the sponsorship of the Naval Medical Research and Development Command.

The stretcher—known as the “portable life support stretcher unit” (PLSSU)—functions as a self-powered, self-contained crash cart during patient transportation. It can supply two to four hours of oxygen; provide ECG monitoring for up to five hours; deliver up to 50 defibrillation shocks; and carry other supplies and equipment needed for suction, resuscitation, and treatment of shock.

When configured for transfer of a patient from the primary care site to a hospital, the PLSSU consists of a standard canvas litter or Stokes litter attached to an equipment carrier that is similar in dimensions and weight to a standard canvas litter with a patient on it. Thus the carrier—which has handles at both ends—can be handled separately and installed like a standard litter in any military evacuation vehicle, with no modification of litter-rack spacing or equipment.

When configured for transporting a patient within the hospital, the PLSSU consists of the equipment carrier and a hospital unit—a bed-like device attached to the carrier by quick-release pins. The height of the hospital unit, when attached to the carrier, is 30 inches—approximately bed height—making for easy transfer of the patient to and from the stretcher. The unit's transparent, uniform-density top and its full-length shelf for X-ray cassettes allow patients to be X-rayed without

being removed from the PLSSU.

The prototype PLSSU has been undergoing testing and evaluation at NRMC San Diego, where it has been used for transfer of critically ill patients both within the hospital and in Medevac operations involving Navy physicians, Navy corpsmen, and Coast Guard helicopters. Trials of the PLSSU at sea have simulated the arrival of casualties by helicopter and landing craft, and their transfer from the flight deck and well decks to medical facilities,

using standard patient-hoist arrangements, pallet-loading vehicles, and Medevac elevators. The PLSSU has demonstrated its capacity to quickly transform utility helicopters into equipped Medevac units. It has also been shown to be fully compatible with civilian and military ambulances, and can quickly convert the latter into a trauma-type van.

Future plans for the PLSSU project include development of a pre-production model, incorporating changes suggested by testing and evaluation.

—Story and photos submitted by W.T. Rasmussen, Ph.D., Head, Biomedical Engineering Branch, Naval Ocean Systems Center, San Diego, Calif. 92152.



Equipment on carrier includes ECG monitor and defibrillator.



NOSC personnel check out PLSSU in an HH-3A helicopter.



# Notes & Announcements

## IN MEMORIAM

CAPT Nellie J. DeWitt, NC, USN (Ret.), a former director of the Navy Nurse Corps, died 22 March 1978 at Carl Vinson Hall in McLean, Va., at age 82.

Born in Susquehanna, Pa., on 16 July 1895, CAPT DeWitt received her nurse's training from the Stamford Hospital Training School, Stamford, Conn., before entering the Navy Nurse Corps during World War I. Her first duty station was at Charleston, S.C. During this time she also had duty aboard the USS *Martha Washington*, a transport ship engaged in carrying dependents and military personnel. She was placed on inactive duty in October 1920, but returned to active duty in October 1922, and subsequently served at many naval medical facilities in the U.S. and overseas.

CAPT DeWitt was promoted to Chief Nurse in April 1937 and served at U.S. naval hospitals in Guantanamo Bay, Cuba; Norfolk, Va.; Corona and Mare Island, Calif.; and at the Hospital Corps School, San Diego, Calif. In September 1944, she went to the Hawaiian Islands to be in charge of nursing activities at the U.S. Naval Hospital, Aiea Heights, with special duties as senior nurse on the Islands. In November 1945, she came to BUMED to assume duty as superintendent of the Navy Nurse Corps, and she was promoted to Captain on 1 April 1946.

An Act of Congress of 16 April 1947 made the Nurse Corps a staff corps of the U.S. Navy and gave its members permanent commissioned officer status, with commensurate pay and allowances. In accordance with this legislation, CAPT DeWitt's title was changed from superintendent to director. She held this position until her retirement on 1 May 1950.

CAPT DeWitt held the World War I Victory Medal, American Defense Service Medal, Asiatic-Pacific Campaign Medal, American Campaign Medal, and World War II Victory Medal.

LCDR Stuart W. McEwen III, MC, USN, a student of Navy Flight Surgeon Class 78-1, died 2 March 1978 in an aircraft accident during training at Naval Air Station Pensacola, Fla.

The 34-year-old physician received his Bachelor of Science degree from Auburn University in 1966 and was awarded his doctorate in medicine from the University of Alabama in 1970. He completed his internship at Charlotte Memorial Hospital, Charlotte, N.C. After

finishing his residency in dermatology at the University of Alabama, he entered the Navy in 1975.

Dr. McEwen served two and a half years as a staff dermatologist at NRMC Jacksonville before reporting to the Naval Aerospace Medical Institute (NAMI) for training as a flight surgeon last September.

He was a member of Alpha Omega Alpha and a Diplomate of the National Board of Medical Examiners and the American Board of Dermatologists. He was posthumously designated a Naval Flight Surgeon.



CAPT N.J. DeWitt  
1895-1978

## INDUSTRIAL AND OCCUPATIONAL HEARING COURSES

The University of Maine at Orono, Bangor, Maine will hold the following courses:

- *15th Annual Industrial Hearing Conservation Institute*, 17-19 July 1978: concerned with responsibilities of industrial nurses and those actively interested in hearing-testing performance and related matters in hearing conservation. Participants are eligible for certification by the Council for Accreditation in Occupational Hearing Conservation and the award of 2.0 continuing education units by the Maine State Nurses Association. Tuition is \$235. Room and board is \$25 per day.
- *26th Annual Institute in Occupational Hearing Loss*, 17-21 July 1978: designed for industrial physicians, safety engineers, otolaryngologists, audiologists, health management executives, and administrative personnel. Covers total field of hearing conservation programs, medicolegal and compensation aspects, and OSHA developments. Awards 27 credits in PRA Category 1 of AMA for physicians. Tuition is \$275. Room and board is \$25 per day.

For descriptive brochures and applications write to: UMO Coordinator, 1721 Pine St., Philadelphia, Pa. 19103, or phone (215) 735-0205.

## DIAGNOSTIC CODING

At the present time there is no mechanism to ensure uniform diagnostic coding of entries not covered in ICDA-8 (Eighth Revision, International Classification of Diseases, Adapted for Use in the United States) or BUMEDINST 6300.3 (Inpatient Data System). Personnel are encouraged to use the services of Mrs. Muriel Brandford, RRA, the Medical Records Administrator at Naval Medical Data Services Center (NMDSC), in the solution of coding problems. Before coming to NMDSC, Mrs. Brandford was director of medical records, Downstate Medical Center, State University Hospital, New York, and a lecturer in the medical record administration program at Downstate Medical Center. Address all inquiries to Commanding Officer (Code 40B), Naval Medical Data Services Center, Bethesda, Md. 20014, or call Mrs. Brandford on Autovon 295-0139.

## AMERICAN BOARD CERTIFICATIONS

(Subspecialties are indicated in parentheses)

### *American Board of Anesthesiology*

CDR Lewis Mantel, MC, USN

### *American Board of Dermatology*

CDR Walter D. Henrichs, MC, USNR

CDR Laut Q. Nguyen, MC, USNR

LCDR Noel T. Brown, MC, USNR

LCDR Robert B. Carlin, MC, USNR

LCDR Stephen R. Damm, MC, USN

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LCDR James M. Kasick, MC, USNR

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LCDR Charles D. Saul, MC, USNR

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### *American Board of Internal Medicine*

CAPT Jean-Jacques Gunning, MC, USN

CDR Kirk E. Hippensteel, MC, USNR

CDR Norman G. Hoger, MC, USNR

CDR Joseph A. Kaufman, MC, USN (Cardiovascular Disease)

LCDR Daniel S. Anderson, MC, USNR (Gastroenterology)

LCDR Peter H. Belott, MC, USNR

LCDR Samuel W. Berg III, MC, USN

LCDR David E. Bybee, MC, USNR (Endocrinology and Metabolism)

LCDR William J. Ceretto, MC, USNR

LCDR Donald C. Gerhardt, MC, USNR (Gastroenterology)

LCDR Bruce K. Lloyd III, MC, USN

LCDR Harry J. Long III, MC, USN (Medical Oncology)

LCDR Leonard P. Neumann, Jr., MC, USNR

LCDR Wallace A. Rolniak, MC, USNR

LCDR George Savides, MC, USN

LCDR Thomas A. Schultz, MC, USNR (Endocrinology and Metabolism)

LT Stanley B. Benjamin, MC, USNR

LT Timothy P. Blair, MC, USNR

LT Fred C. Brown II, MC, USNR (Gastroenterology)

LT Michael D. Mottet, MC, USNR

LT Charles R. Rost, MC, USNR

### *American Board of Obstetrics and Gynecology*

CAPT Joseph L. Yon, Jr., MC, USN (special competence in Gynecologic Oncology)

CDR Grady G. Barnwell, MC, USN

LCDR Alan R. Alexander, MC, USN

LCDR Stephen B. Ganderson, MC, USN

LCDR Robert J. Hartman, MC, USN

LCDR David R. Lecloux, MC, USNR

LCDR William L. Lynn III, MC, USNR

LCDR George A. Ritcher, MC, USNR

### *American Board of Orthopaedic Surgery*

CDR Bjorn C.J. Eek, MC, USNR

LCDR Albert E. Becker, Jr., MC, USN

LCDR James H. Deweerdt, Jr., MC, USNR

LCDR William A. Herndon, MC, USNR

LCDR James R. Lafleur, MC, USNR

LCDR James J. McCoy, Jr., MC, USNR

LCDR Joseph M. Ricciardi, MC, USNR

LCDR James R. Schneider, MC, USNR

LCDR Joseph E. Trader, MC, USNR

LCDR John F. Znider, MC, USNR

### *American Board of Otolaryngology*

LCDR Graham Gilmer III, MC, USN

LCDR Drew G. Sawyer, MC, USNR

LCDR Edward J. Silvoy, MC, USNR

LCDR George C. Swanson, MC, USNR

### *American Board of Pathology*

CAPT John A. Henderson III, MC, USN

LCDR Michael A. Fitzsimmons, MC, USN

LCDR James R. McCole, MC, USNR

LCDR Arjang K. Miremadi, MC, USNR

LT Robin S. Foerster, MC, USNR

### *American Board of Pediatrics*

CDR Bedford W. Bonta, MC, USN (Neonatal-Perinatal Medicine)

CDR Thomas M. Connor, MC, USNR

LCDR Kenneth C. Castor, Jr., MC, USN

LCDR Edward G. Hayhurst, MC, USNR

LCDR Gary A. Incaudo, MC, USNR

LCDR John W. Kuhn, MC, USNR

LCDR Lewis Otero, MC, USNR

LCDR William J. Thomas, MC, USNR

LCDR Richard D. Torkelson, MC, USNR

LCDR Eric A. Wulfsberg, MC, USN

### *American Board of Plastic Surgery*

CDR George E. Siegfried, MC, USN

### *American Board of Preventive Medicine*

LCDR Edward P. Horvath, Jr., MC, USNR (Occupational Medicine)

### *American Board of Psychiatry and Neurology*

CAPT Stanley J. Kreider, MC, USN

### *American Board of Radiology*

LT M.L. Safer, MC, USNR (Therapeutic Radiology)

### *American Board of Surgery*

LCDR Danny V. Cantwell, MC, USNR

LCDR Bruce D. Baird, MC, USNR

LCDR Richard A. Mayo, MC, USN

LCDR George D. Miller, MC, USN

LCDR John J. Tepas III, MC, USN

LCDR Charles F. Yeagle III, MC, USNR

## Instructions and Directives

### Medical Malpractice Claims

Before Public Law 94-464 was enacted, the doctrine of legal immunity protected some health officials from suit; however, the outcome of judicial decisions in individual situations could not be predicted with any certainty. The intent of Congress in passing the law was to insulate all Department of Defense, Coast Guard, and Central Intelligence Agency medical personnel from the expense of defending malpractice suits and paying judgments or settlements.

PL 94-464 covers all Armed Forces, DOD, and CIA physicians, dentists, nurses, pharmacists, and paramedical or other supporting personnel—including medical and dental technicians, nursing assistants, and therapists—performing medical, dental, or related health-care functions (including clinical studies and investigations), if the alleged malpractice occurred while they were acting in the scope of their duties or employment.

The law applies only to those claims filed on or after 8 Oct 1976.

“Scope of employment” is considered to mean all officially assigned duties. This includes, among other things, health care performed by Navy personnel assigned to a civilian hospital, and health care performed by civilians training with or otherwise assigned to the Navy. “Scope of employment” does *not* include employment of Navy personnel at civilian health-care facilities during nonduty hours (“moonlighting”).

PL 94-464 extends coverage within the U.S. and its possessions by making suit against the United States under the Federal Tort Claims Act the exclusive remedy for an injured party. In those situations where the act does not apply (e.g., where the actions giving rise to the claim occurred outside the United States), the law allows the Secretary of Defense to hold harmless, or provide liability insurance for, health-care personnel. DOD Directive 6000.6 of 24 Aug 1977 delegates this authority to the Secretary of the Navy for Navy health-care personnel.

All Navy health-care personnel in the categories described above are held harmless for damages resulting from negligent or wrongful acts or omissions while acting within the scope of duties and assigned to duty in a foreign country, or detailed for service with other than a federal agency, or if the circumstances are such as are likely to preclude remedy against the United States

under the Federal Tort Claims Act.

Health-care personnel of the Department of the Navy who are sued for Navy-related activities shall immediately deliver all process and pleadings served upon them (or an attested true copy) to the commander of the naval installation to which they were attached at the time of the incident giving rise to the suit.

Upon receiving process and pleadings, the commanding officer shall promptly furnish copies to the appropriate U.S. Attorney, to the Attorney General, and to the Secretary of the Navy (Judge Advocate General).

Upon receipt of process or pleadings—or upon notice of any claim or potential claim—an investigation conforming to Chapter XX, *JAG Manual*, shall be conducted promptly, and the commanding officer shall report in the endorsement whether or not the acts giving rise to the claim were performed in the scope of official duties or employment.

Upon learning that a claim or lawsuit has been filed, the commanding officer shall immediately notify the Judge Advocate General (Code 14C), by message or telephone. If no investigation has been conducted, one will be expedited. Certified copies of all claims, service of process, and pertinent papers shall be forwarded by ordinary mail to the Judge Advocate General and to the officer in charge of the nearest Naval Legal Service Office.

The Judge Advocate General may redelegate authority and assign tasks to appropriate naval commands to ensure that: (1) liaison is maintained with the Attorney General and the appropriate U.S. Attorney; (2) the Attorney General has adequate information on which to base the scope of employment determinations required by PL 94-464; (3) all cases are monitored to ensure that, whenever appropriate, they are transferred to the appropriate U.S. District Court and deemed a tort case against the United States; and (4) arrangements are made, through the Department of Justice, to defend actions brought against any Navy health-care personnel for acts performed in the scope of their duties or employment. The procedures of the Military Claims Act (Title 10, U.S. Code, Section 2733) shall be used to determine costs, settlements, or judgments against such individuals. [Note: Questions about this instruction may be directed to BUMED Code 003; Autovon 294-4388. Ed.]—SECNAVINST 6300.3 of 14 March 1978.

## How to Get the Training You Want

Application time is here. Scholarship students who will graduate in late 1978, or in May or June 1979, are beginning to make decisions about training that will determine to a great extent their professional future. The Navy must figure prominently in these plans.

Most of you will serve an operational or nonspecialty tour during your continuum of professional experience in the Navy. As presently projected, this operational tour will be scheduled at the end of your first year of graduate medical education when the interruption will least disrupt your training and when the experience will contribute substantially to your development as a Navy physician.

We have consolidated many first-year training positions in the medical and surgical specialties into a basic medicine and basic surgical training year. These broad-based programs will provide the educational foundation for entry into specialty training.

We know that you have many questions about your training. Navy Medical Department program managers have already discussed with many of you your concerns, reservations, and questions about your future. To help you further, we are publishing here general guidelines on the application process, portions of the application package which will be sent to you this month, and a list of directors of medical education at the Navy's training hospitals.

### GENERAL GUIDELINES

1. The Navy is no longer seeking first-year trainees under the National Intern and Resident Matching Program of the American Medical Association (AMA). It is essential that you, as a participant in a Navy subsidy program, know this.

2. In accordance with the provisions of the Armed Forces Health Professions Scholarship Program (AFHPSP), you are required to apply for your first year

of graduate medical education in the Navy. The following schedule will apply:

1 May 1978—Scholarship students entering (or about to enter) their senior year will receive a list of first-year positions available in 1979. Application forms and instructions will also be supplied.

1 Sept 1978—Closing date for receipt of applications in the Bureau of Medicine and Surgery.

September 1978 (exact date to be announced)—Selection committee meets in Washington, D.C., to select first-year trainees for all hospitals.

October 1978 (exact date to be announced)—Candidates advised of their selection or nonselection.

15 Nov 1978—Notification of selection or nonselection for deferments mailed to students who have requested deferment of more than one year.

3. We plan to offer 252 first-year positions in eight naval hospitals. Programs will include basic medicine, basic surgery, family practice, obstetrics/gynecology, pediatrics, and psychiatry.

Programs in basic medicine and basic surgery will be broad-based. Programs in family practice, obstetrics/gynecology, and pediatrics will consist of 12 months in a single discipline. First-year training in psychiatry will consist of no more than three months of psychiatry, four months of internal medicine, and other electives.

All students who wish to continue beyond the first year of graduate medical education will be required to reapply for training.

4. AFHPSP students must list *all* naval hospitals, in order of preference, that offer the training program they desire. Candidates may also list alternate program preferences, with hospital preferences for these alternate choices. AFHPSP students who do *not* list all naval hospitals that offer their desired program will be assigned preferences for the unlisted hospitals. Additional specialty preferences will not be assigned, however.

It is important that candidates for all basic medicine



## PROGRAM DIRECTORS

CDR R.W. Higgins, MC, USN  
Naval Regional Medical Center  
Charleston, S.C. 29403

CDR S.A. Borel, MC, USN  
Naval Regional Medical Center  
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CAPT C.L. Gaudry, Jr., MC, USN  
Naval Regional Medical Center  
Jacksonville, Fla. 32214

CDR E.L. Taylor, MC, USNR  
Naval Aerospace and Regional  
Medical Center  
Pensacola, Fla. 32512

CAPT D.R. Cordray, MC, USN  
Naval Regional Medical Center  
Portsmouth, Va. 23708

CDR Walter V.R. Vieweg, MC,  
USN  
Naval Regional Medical Center  
San Diego, Calif. 92134

CDR D.M. Robinson, MC, USN  
Naval Regional Medical Center  
Oakland, Calif. 94627

CDR C.R. Mock, MC, USN  
National Naval Medical Center  
Bethesda, Md. 20014

**At the Bureau of Medicine and Surgery:**  
CAPT S.J. Kreider, MC, USN  
BUMED Code 0011  
Washington, D.C. 20372  
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CDR C.B. Mohler, MSC, USN (Ret.)  
BUMED Code 314  
Phone: (202) 254-4339

**At the Naval Health Sciences Education  
and Training Command:**  
CDR C.T. Cloutier, MC, USN  
HSETC Code 4  
Bethesda, Md. 20014  
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COLLEGE RANK IN CLASS NAVPERS 1100/15 (6-69) (Formerly NAVPERS 1028)				FORM APPROVED BUREAU NAVAL 100 45-8 287		
NAME		DATE OF BIRTH		APPLICANT FOR:		
YEARS OF ATTENDANCE	MAJOR	SEM. CTH. HOURS CREDITED TO DATE (Undergraduate)	GRADE AVERAGE	TYPE OF DEGREE	DATE OF GRADUATION (Undergraduate)	
NAME IN CLASS	NUMBER OF GRADUATES	INSERT NUMERICAL RANKING OR APPROPRIATE PHRASE, SUCH AS "UPPER TENTH", "MIDDLE TENTH", "LOWER TENTH"				
ASSOCIATION WITH ROTC UNIT AT SCHOOL		ROTC BRANCH OF SERVICE				
<input type="checkbox"/> IS ASSOCIATED <input type="checkbox"/> WAS ASSOCIATED		<input type="checkbox"/> ARMY <input type="checkbox"/> NAVY <input type="checkbox"/> AIR FORCE <input type="checkbox"/> NOT ASSOCIATED				
Based upon observation while a student at this institution, he is (is not) recommended for the program for which applying.						
The guide lines below are furnished to assist you in evaluating the applicant's personal characteristics, and to standardize the grading to the greatest extent possible:						
OUTSTANDING ..... No other person of superior caliber known by the person making the evaluation. EXCELLENT ..... Well above average. Very few superiors. GOOD ..... Generally average. Equal to the majority of persons in the applicant's age and experience groups. SATISFACTORY ..... Generally below average, but acceptable. UNSATISFACTORY ..... Not acceptable.						
		OUTSTANDING	EXCELLENT	GOOD	SATISFACTORY	UNSATISFACTORY
PROFESSIONAL ABILITY						
SERIOUSNESS OF PURPOSE						
INITIATIVE						
PERSONALITY						
APPEARANCE						
ABILITY TO INSPIRE CONFIDENCE						
CAPACITY FOR INDEPENDENT THINKING						
COOPERATIVENESS AND RECEPTION OF CRITICISM						
GRADUATE SCHOOL STUDENTS ONLY						
1. The above named applicant						
<input type="checkbox"/> Is a student in good standing in his _____ year of studies toward the degree of _____ <span style="margin-left: 300px;">OR</span> <input type="checkbox"/> Has been accepted for the next entering class convening on _____						
2. If he continues his studies on an uninterrupted schedule, he may expect to graduate on the _____ day of _____, 19____. (Exact day of expected graduation required if in senior year.)						
3. Class standing for years of completed studies (use relative or percentile ranking; if student is not ranked, give adjective rating of Outstanding, Excellent, Good, Satisfactory, Unsatisfactory):						
First year _____ standing in class of _____						
Second year _____ standing in class of _____						
Third year _____ standing in class of _____						
SENIOR MEDICAL AND SENIOR DENTAL PROGRAM APPLICANTS ONLY						
DATE OF COMPLETION OF 30 YEAR		DATE THE 4TH YEAR OF STUDY (Including Clinical Work required as part of 1st year) WILL BEGIN				
NAME OF INSTITUTION		SIGNATURE OF SCHOOL OFFICIAL		DATE		

S/N 0106-020-0500

## IMPORTANT

This package contains important information concerning pathways that are available to you for graduate medical education. Read it carefully and submit your application in accordance with the instructions provided.

If you will be graduating prior to May or June 1979, and you are selected for training in the Navy, your training will commence upon graduation providing the director of the program for which selected has a vacancy in his training quota at that time. If there is no such vacancy, your training will commence on 1 July 1979. The scholarship stipend will be discontinued for students in the Armed Forces Health Professions Scholarship Program on the date of completion of requirements for their degree if more than 45 days will elapse prior to receipt of the degree. Candidates who receive their degree early but cannot commence training prior to 1 July 1979 will be considered on an individual basis for temporary active service at their hospitals to await the commencement of training.

College Rank in Class Form

FIRST YEAR GRADUATE MEDICAL EDUCATION APPLICATION  
NAVMED 152/3(15-77)

Please read Privacy Act Statement on reverse.

From: \_\_\_\_\_  
(Rank) (Name) (SSAN)

Address: \_\_\_\_\_

To: Chief, Bureau of Medicine and Surgery (ATM: Code 314), Navy Department, Washington, D.C. 20372

Subject: Graduate Medical Education and appointment in the Navy Medical Corps; application for  
(for use only by students in their last year of medical or osteopathic school)

Encs: (1) Physical condition statement

1. It is requested that this letter be considered as my application for the training program(s) that are listed below in the order of my preference and, if I hold an appointment in a Navy student program it is requested that it also be considered as my application for an appointment in the Navy Medical Corps.

PROGRAM	SPECIALTY INTEREST	HOSPITAL PREFERENCE

**INSTRUCTIONS:** Under "PROGRAM" indicate the programs of your choice as noted on the enclosed listing. If Basic Medicine or Basic Surgery is stated as a preference, indicate in column headed "SPECIALTY INTEREST" the specialty that you plan to eventually enter. Such a statement of preference will not be binding but will reflect only your interest at this time. Under "HOSPITAL PREFERENCE" list hospitals from left to right in order of preference that offer the program sought.

**REMARKS**

Check one of the blocks.

- ☐ Prime preference is for Navy program.  
☐ Prime preference is for civilian program.  
☐ No prime preference.

Additional pieces of paper can be attached to provide the selection committee with any special information you desire to have considered.

2. Enclosure (1), the statement of my physical condition, is forwarded for inclusion in my file.

3. Under separate cover I shall have the dean of my school provide an up-to-date transcript of my grades and a letter of recommendation. I understand that additional letters of recommendation can be forwarded to the Bureau of Medicine and Surgery at the address previously noted in this letter.

4. In the event a training position is not available for me in a naval hospital, it is requested that I be granted a deferment of my active service obligation until I shall have completed training in a civilian institution as noted below (Applicable only to students in the Armed Forces Health Professions Scholarship Program and Ensigns 1915).

SPECIALTY \_\_\_\_\_

TO BE COMPLETED ON \_\_\_\_\_

month/year

5. I understand that if I am not selected for training in a naval hospital and I am not granted a deferment to complete full specialty training in a civilian institution, my active service will be delayed for one year only to participate in one year of graduate medical education in a civilian institution. At the end of that period I will be called to active service. (Applicable only to students who hold appointments in Navy student programs).

Signature \_\_\_\_\_

Telephone Number \_\_\_\_\_ Date \_\_\_\_\_

EXACT date of anticipated graduation  
Month - Day - Year

If you will complete the course requirements for your degree more than 45 days prior to the anticipated date of graduation, please indicate the completion date in this space: \_\_\_\_\_

Number of Dependents \_\_\_\_\_

I am a participant in: (Check one)

Graduate Degrees \_\_\_\_\_ Major \_\_\_\_\_

- ☐ Active Duty Medical/Osteopathic Student Program  
☐ Armed Forces Health Professions Scholarship Program  
☐ Senior Medical Student Program  
☐ Ensign (1915) Program  
☐ None of the above

**Privacy Act Statement:** Under the authority of 10 USC, 5 USC 301 and Executive Order 9397, information requested herein will be used to evaluate your application for graduate medical education. Disclosure of the information is voluntary, but failure to provide the information may result in delay and possible disapproval of the application.

PROGRAMS IN GRADUATE MEDICAL EDUCATION OFFERED  
TO GRADUATING MEDICAL & OSTEOPATHIC STUDENTS  
IN THE 1979 - 1980 TRAINING YEAR

	FAM PRAC	OB/GYN	PEDS	PSYCH	BASIC MED	BASIC SURG	TOTAL
CAMP PENDLETON	9						9
CHARLESTON	9						9
JACKSONVILLE	9						9
PENSACOLA	8						8
BETHESDA		3	2	4	24	16	49
OAKLAND		3	2	3	20	15	43
PORTSMOUTH VA		6	3	4	22	18	53
SAN DIEGO		6	3		39	24	72
TOTAL	35	18	10	11	105	73	252

**Special Notes:** (A) 1st yr. programs in Fam Prac, OB/GYN, and Peds will be 12 months in a single discipline.

(B) Programs in Psych will offer a broad-based clinical year to include 4 months in Int Med, not more than 3 months in Psych, plus electives.

(C) The Basic Med and Basic Surg training year will contain a minimum of 4 months of Int Med, 4 months of Surg, plus electives. These programs are structured in order to provide the trainee with the background required to enter training in specific specialties at later dates. Current plans are that trainees in Basic Med will be prepared to enter residency programs in Anes, Derm, Int Med, Neuro, Opth and Radio. Basic Surg Trainees will be prepared to enter residency programs in all surgical specialties including Oto, Ortho, Urol, Gen Surg and Neuro Surg. Ample opportunity will exist for crossovers into other specialties after completion of the first year of Graduate Medical Education in any of the programs listed in the breakdown at the top of this page.

(D) Electives will be offered according to the trainees preference as approved by the program director.

(E) All selections for first year GME are for one year only. All trainees who desire to continue training beyond that year must reapply upon reporting to their training hospital.

and basic surgery programs state the discipline in which they are currently interested. Candidates may use the remarks section of the application to draw the selection committee's attention to any important personal considerations.

**5. Selection for Navy programs:** AFHPSP students who are selected for a training program in a naval hospital will be *required* to enter that program. Scholarship students who state inappropriate preferences for specialties not listed as available (such as pediatric allergy, gastroenterology, and plastic surgery) will be considered for training positions in the basic specialty—pediatrics, basic surgery, basic medicine, etc.

**6. Nonselection for Navy programs:** Scholarship students not selected for training programs in a naval hospital will be so advised, and will be free to seek first-year graduate medical education positions in the civilian sector.

**7. Active-duty deferments:** At the same time they apply for Navy training programs, AFHPSP students who desire a full residency in a civilian institution must request permission to delay serving their active-service obligation in order to participate in such training. The civilian institution need not be named, but the desired specialty and length of the delay must be clearly stated. Students *not* selected for Navy programs will be advised in time to allow them to submit lists of preferred civilian institutions to the National Intern and Resident Matching Program (AMA) or the Intern Registration Program of the American Osteopathic Association (AOA).

Students who are not selected for Navy programs, or for active-duty delays to complete full training in a specialty, will be assured a maximum of one year's delay in order to complete an internship or the first year of graduate medical education in a civilian institution. Prior to 15 August of this "delayed" year, they may then apply for a deferment to complete a full residency.

If applications for second-year positions or deferments cannot be approved, students will be called to active service as general medical officers at the end of their first year of training. In subsequent years they will be eligible to apply or reapply for residencies in naval hospitals. If not selected, they may apply or reapply for release from active duty in order to pursue a residency in a civilian institution. Upon completion of training, they must return to active service to fulfill their remaining obligation.

All requests for residencies and active-duty delays will be considered in light of the Navy's anticipated needs. Candidates are cautioned that requests to complete full specialty training, whether in a naval hospital or a civilian institution, may not be approved. The needs of the Navy must remain paramount. However, all candidates are assured of completing one year of

graduate medical education in either a Navy or a civilian program.

Students who will begin their first year of graduate medical education in 1978 have been advised by separate correspondence of the procedure through which they can apply for further training in the Navy or for active-duty delays to complete full specialty programs.

It is essential that all scholarship students prepare themselves for the contingency that numerical limitations may preclude their selection for first-year programs in naval hospitals. Candidates are urged to register with the National Intern and Resident Matching Program (AMA) or the Intern Registration Program (AOA). Of course, students who wish to seek training on their own, if not selected by the Navy, are free to do so. Students registered with an intern placement plan will withdraw from the plan if selected for a Navy program.

As in the past, the Navy will offer unfilled first-year positions to qualified students who do not obtain positions under the AMA or AOA placement plans. Information concerning such vacancies will be available each year after the AMA and AOA placement announcements are made.

**8.** Students are urged to visit the naval hospitals in which they are interested for interviews, the results of which are forwarded to BUMED to become part of the student's application file. Interviews must be completed prior to 15 Aug 1978; results must be received in BUMED before 1 September. Candidates should not consider a program director's indication of acceptance as the final placement determination. It is not uncommon for two or more program directors to state a preference for the same candidate, and in such cases a decision must be made through the internal Navy matching operation. The results of this matching may place a candidate in a hospital or a program that is lower on his or her preference list than anticipated.

**9.** The provisions of these guidelines that pertain to active-duty delays, and the requirement to state multiple hospital preferences, do not apply to students in the Medical and Osteopathic Scholarship Program (MOSP). These students may continue to apply to as many Navy and civilian programs as they desire. However, they may participate in civilian training programs only during their first year of graduate medical education. Application procedures for training in naval hospitals are as stated in these guidelines, and the schedule of dates pertains.

**10.** It is the responsibility of students to arrange for their medical or osteopathic school dean to complete the college-rank-in-class form and append to it a copy of the student's up-to-date transcript and a letter of recommendation, to be forwarded to the Bureau of Medicine and Surgery.

## Features

# THE NURSE CORPS:

## Seventy Years Old, but Young at Heart

In this, our seventieth year, it is heartening to reflect on the vitality of the Navy Nurse Corps. As the saying goes, we're not getting older; we're getting better.

The Navy nurse of today is quite different from his or her sister of 1908. The Nurse Corps officer of 1978 can be found filling a wide variety of positions, all of them vital to the mission of the Medical Department.

In the area of clinical practice, Navy nurses are serving as nurse anesthetists, primary care practitioners, and clinical specialists, as well as in the more traditional clinical roles.

In the educational field, there are Nurse Corps officers involved in continuing education, staff development, specialized skill training, curriculum development, patient education, and the administration of education programs.

In addition to nursing service administration, some Nurse Corps administrators have been assigned to executive medicine billets.

In celebration of this anniversary, the Nurse Corps officers pictured here are some of those who have been nominated by their commands as representative of the hundreds of outstanding individuals whose dedication has made the Nurse Corps what it is today.

To all of you, a very happy Birthday, and many, many more.

*Maxine Conder*

MAXINE CONDER  
Rear Admiral, NC, USN  
Director, Navy Nurse Corps

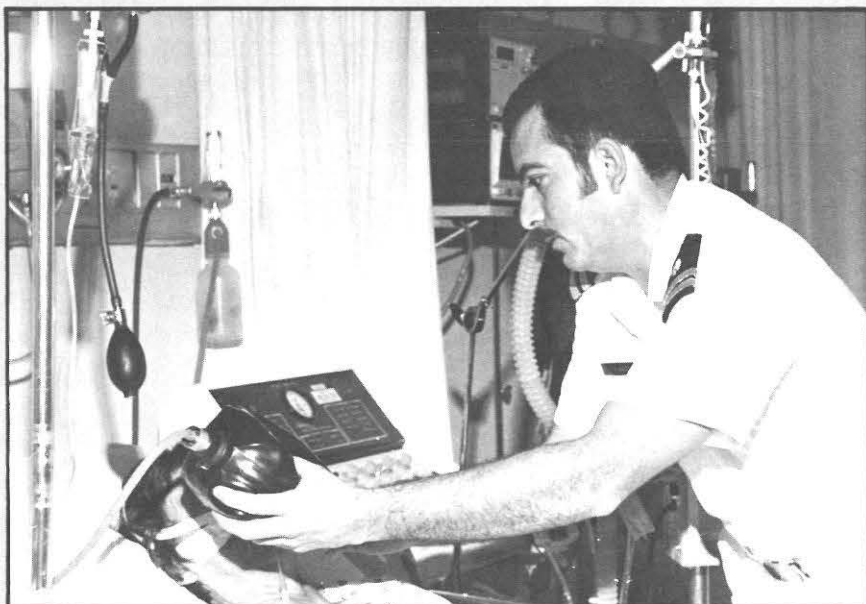
LTJG Sandra Lee Block (USNR) was selected as one of the nurses to staff the new Intensive Care Unit at NRMC Jacksonville. An outstanding bedside nurse, she is skilled in administering specialized care to coronary and critically ill patients. On the unit, she teaches as she works, sharing her knowledge with nurses, corpsmen, and patients.





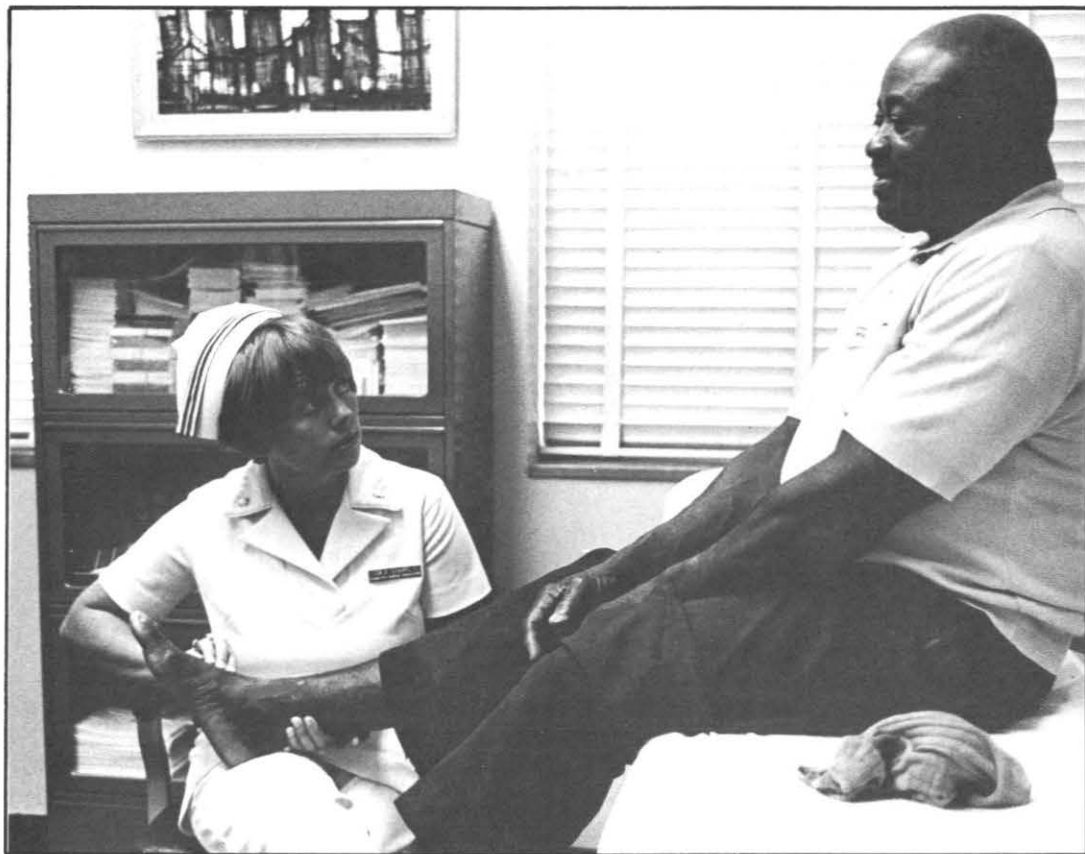


(Below) In addition to serving as a skilled member of the Critical Care Unit staff at NRMCC Corpus Christi, LT Jose Blanco (NC) is a registered emergency medical technician instructor. He assists in presentation of the command-sponsored Emergency Medical Technician Course and has also conducted cardiopulmonary resuscitation classes. (Bottom) LT Rachel V. Allison (USNR) introduces new Marines to the benefits of Navy medicine. As senior nurse at the Naval Hospital Beaufort Branch Clinic, Marine Corps Recruit Depot, Parris Island, S.C., she has overall supervision of the psychiatric ward, emergency room, cool room, central supply, and recruit processing section.



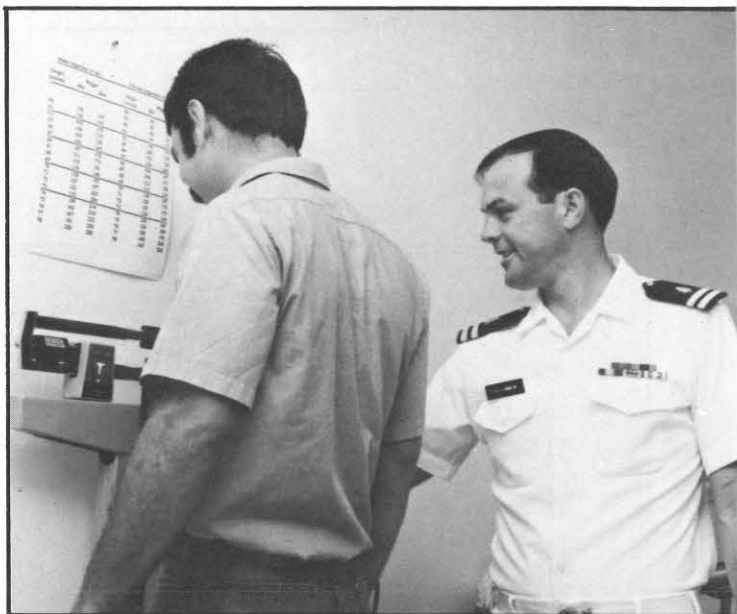
## NURSE CORPS (continued)

Assigned as primary care coordinator on the diabetes team at NRMCC Oakland, LCDR Barbara Schupeltz (USNR) has earned much credit as a nurse educator. Since her work began, says her command, "we have seen an increased awareness, interest, and compliance in our patient population. This has resulted in fewer hospitalizations and, we believe, a better quality of life for the patient with diabetes."



Of CDR S. Ann Ross (above left), her commanding officer at NRMCC Camp Lejeune says: "She belies George Bernard Shaw's dictum that 'He who can, does; he who cannot, teaches,' by being a dedicated doer in addition to an eminent teacher. Her contributions to our delivery of intensive care are measured in lives, not words." (Right) LT Alexandra Geeza (USNR), clinical instructor at NRMCC Great Lakes, brings ingenuity and creative talent to her work, often making her own clever visual aids for use in educational programs.





(Top left) CDR Julia O. Barnes, chief of nursing service at NH Lemoore, Calif., has made a notable contribution to her command's accomplishment of mission. Like most chief nurses, she can be found in the hospital early in the morning and late at night, helping out and providing guidance where needed. (Top right) LT Richard A. Dunn (NC) has been responsible for a number of initiatives that have benefited patients and staff at NRMH Hawaii. He served on the committee that established a regional Emergency Technician Course and is now one of the course instructors. He also initiated and then managed a weight control program for active duty personnel with an 85% success rate. (Left) LT John E. Robson, a designated SAR nurse attached to NH Whidbey Island, Oak Harbor, Wash., ensures continuity of nursing care to patients aboard MED-EVAC helicopters. An active member of the Emergency Nurses Association, LT Robson is dedicated to providing quality care in all areas of emergency medicine.

## Other Nominees

The officers pictured on these pages are only some of the outstanding nurses who were nominated by their commands for special recognition in this issue. Space does not permit us to include all nominees, but we wish to recognize here those nominated officers whom we cannot picture.

LTJG Steven E. Anderson, NC, USNR, NRM C San Diego, Calif.; LT John Boyer, NC, USN, USNH Roosevelt Roads, P.R.; LT Carolyn Z. Carlton, NC, USN, NRM C Orlando, Fla.; CDR Clarence Cote, NC, USN, NRM C Newport, R.I.; LCDR Elaine B. Hicks, NC, USN, NRM C Memphis, Tenn.; LT Joan Huber, NC, USN, NSMC New London, Groton, Conn.; LT Judith Lombardi, NC, USN, NRM C Charleston, S.C.; LCDR Barbara R. Matuszewski, NC, USN, NRM C Orlando, Fla.; LTJG Kathleen A. McDonald, NC, USNR, NRM C San Diego, Calif.; LT Kristine E. Minnick, NC, USNR, U.S. NRM C Guam, M.I.; LTJG Gaither Pennington, NC, USNR, NRM C Portsmouth, Va.; LTJG Diane F. Quackenbush, NC, USN, NRM C Oakland, Calif.; LCDR Karen A. Rieder, NC, USN, NRM C Oakland, Calif.; CDR Cynthia A. Schultz, NC, USN, U.S. NRM C Okinawa, Japan; LT Elinor J. Spita, NC, USN, NRM C Philadelphia, Pa.; LTJG Edward Uldrich III, NC, USNR, NRM C New Orleans, La.; LCDR Patricia Willhelm, NC, USN, USNH Guantanamo Bay, Cuba; ENS Eliot Winecour, NC, USNR, NRM C Portsmouth, Va.; LCDR Ann Yahner, NC, USN, NH Cherry Point, N.C.; LT Nancy Zabel, NC, USN, NRM C Long Beach, Calif.

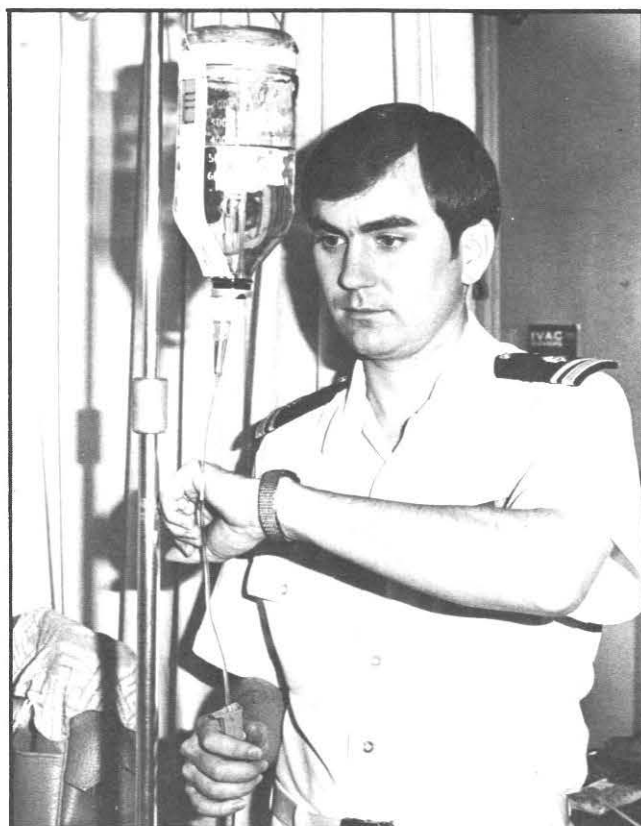


Recognized for her professional expertise as senior nurse anesthetist at NH Patuxent River, Md., LCDR Fay Wray also functions as inservice coordinator. She has compiled a booklet on inhalation therapy and has taught it to civilian and military staff. Practicing what she preaches about the value of O<sub>2</sub> to healthy body tissue, CDR-selectee Wray keeps fit by jogging.





(Left) As educational coordinator at U.S. NRMC Yokosuka, Japan, LT Michael Monahan (NC)—shown here aboard the USS **Constellation**—has been instrumental in providing training and nursing care support to shipboard medical departments. As a result, shipboard visits, consultative services, and training programs for shipboard corpsmen have become a regular part of fleet services at Yokosuka. (Bottom left) U.S. NRMC Subic Bay, R.P., nominated LT Nancy J. Owen for special recognition because of her "unique ability to inspire peers and subordinates to increase their knowledge and skill and function to the fullest extent of their potential. She readily accomplishes projects which others consider difficult or impossible." (Bottom right) LTJG Robert E. Butzow, NC, USNR, has made exceptional contributions to nursing service and the mission of NH Port Hueneme, Calif. His versatility and adaptability in crisis staffing situations have been outstanding, and he has continued to seek out new learning experiences, excelling in all his endeavors—particularly as a guide and teacher of corpsmen.



## Education & Training

# Opportunities for Nurse Corps Officers

Nurse Corps education and training is administered through the Naval Health Sciences Education and Training Command. The Nurse Corps Programs Directorate within HSETC is responsible for planning, coordinating, administering, and evaluating the various education and training programs to meet requirements set forth by the Bureau of Medicine and Surgery.

Educational opportunities open to Nurse Corps officers include:

**Full-time duty under instruction.** The assignment to full-time duty under instruction prepares Nurse Corps officers to function more effectively and to assume positions of increased responsibility. It provides a program of continuing education for Navy nurses while they are on active duty and enhances retention.

While they are attending school, all Nurse Corps officers receive full pay and allowances of their rank, in addition to all tuition costs.

The service obligation for undergraduate and nondegree full-time instruction is two years for the first year of education and six months for each additional six months or part thereof. The service obligation for graduate education is three times the length of the education, for the first year or portion thereof, and six months for each additional six months or part thereof. (See BUMEDINST 1520.14 series.)

• Undergraduate, graduate, and doctoral programs: Full-time instruction in civilian colleges and universities—in General Nursing, Nursing Service Administration, Nursing Education, Research, Clinical Specialties, and Nurse Practitioner programs—is offered to qual-

ified Nurse Corps officers in the Regular Navy.

• Naval Postgraduate School, Monterey: Offers a course in Navy Manpower/Personnel Management, leading to an M.S. degree, to qualified Nurse Corps officers in the Regular Navy.

• Anesthesia program: A two-year, Navy-sponsored program established to meet the demands for, and replenish the supply of, registered nurse anesthetists. The program is accredited by the American Association of Nurse Anesthetists and consists of one academic year of study at George Washington University, Washington, D.C., and 15 months of clinical training at selected naval regional medical centers. The university offers an option for the student to elect to fulfill academic requirements leading to a B.S. degree in Nursing Anesthesia. The additional requirements for the degree may be met before or after completion of the nondegree program.

The anesthesia program is available to Nurse Corps officers of the Regular and Reserve Navy on active duty. One year of college-level science, to include a semester of chemistry, is a prerequisite.

• Nurse practitioner program: As a result of increasing demands for nurse practitioners, full-time duty under instruction is offered to prepare Nurse Corps officers to function as primary care nurse practitioners in the areas of Family Practice, Pediatrics and Ob/Gyn. Courses are offered to both Regular and Reserve officers in nondegree programs, and to nurses of the Regular Navy in civilian Master's degree programs.

**Operating-room orientation.** This course offers junior Nurse Corps officers an opportunity to become acquainted with the range of technical skills basic to effective patient care in the operating room. The nurse will then easily adapt previously learned scientific principles to this specialty area. The course consists of six weeks of temporary additional duty (TAD) funded by HSETC. Upon completion, the Nurse Corps officer will return to the originating command for assignment in the operating room at the beginning staff nurse level.

**Short courses.** Short courses, institutes, seminars, and workshops conducted by other federal agencies, civilian universities, institutions, and professional organizations, along with Navy-sponsored short courses offered at naval regional medical centers, constitute a means by which all Nurse Corps officers may acquire continuing education. These courses are offered as a retention factor as well as a requirement for relicensure and individual development of expertise. (See BUMEDINST 4651.1 series.)

**Part-time outservice instruction.** Tuition aid for part-time study in civilian universities in off-duty hours is offered to nurses working toward further nursing education and willing to obligate themselves for two years upon completion of the last course. (See BUMEDINST 1500.7 series.)

**All inquiries** regarding Nurse Corps education should be addressed to: Commanding Officer, Health Sciences Education and Training Command (Code 7), NNMCMC, Bethesda, Md. 20014.

# Factors Contributing to Work-Related Accidents Aboard U.S. Navy Ships

LT Mark C. Butler, MSC, USNR

Allan P. Jones, Ph.D.

LT James M. La Rocco, MSC, USN

The identification of factors influencing work-related accident or injury continues to be a problem of considerable concern to naval service personnel. Such accidents, especially aboard ship, often lead to serious decrements in work group performance and thus impair overall operational readiness.

In a review of studies examining causes of industrial accidents, Surry (1) concluded that individual and environmental factors were important contributors to accident morbidity, although few attempts have been made to integrate such factors into an overall framework.

Recent work by Pugh, Erickson, and Jones (2) represents an initial step toward the development of a more comprehensive perspective. These authors investigated the relative influences of work area conditions and individual characteristics upon perceptions of safety and actual trauma rates aboard Navy ships. At the division level, quality of equipment, worker experience, job standards, and the degree of congruity between individual abilities and specific job requirements were found to be more strongly related to safety judgments and actual trauma rates than were individual difference measures. In addition, such relationships were strongest for division members who normally worked in hazardous surroundings and who also perceived their work environment as extremely unsafe.

Building on these findings, Gunderson (3) focused more specifically on accident and trauma differences among various shipboard divisions. He reported that

From the Environmental and Social Medicine Division, Naval Health Research Center, San Diego, Calif. 92152, where LTs Butler and La Rocco are research psychologists and Dr. Jones is Head, Fleet Medicine Branch.

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the members of Engineering Divisions (i.e., boiler technicians and machinist mates) perceived their work area environments as extremely unsafe and experienced higher accident and injury rates than did members of all but one of the remaining ship divisions.

The one exception occurred among members of Deck Maintenance Divisions. Personnel in these divisions perceived their work environment as only slightly below average in area safety, whereas their trauma rate was higher than that of divisions whose work areas were evaluated as the most hazardous on the ship. In fact, Deck Maintenance Divisions reported accident rates equal to or slightly higher than those reported by Engineering Divisions.

Such findings raised several questions about the effects of situational hazards on work-related trauma. For example, personnel in the Engineering Divisions work in the boiler room and in other machinery-oriented spaces aboard ship. High trauma rates for these men might be explained rather simply by situational factors such as equipment-related hazards. Deck personnel, on the other hand, while reporting the highest trauma rates, did not evaluate their work environments as unusually hazardous. Thus, it is necessary to explore whether other, nonequipment factors might be responsible for the trauma rates experienced by these individuals.

### POSSIBLE EXPLANATIONS

One possible explanation for the Deck Maintenance anomaly might be that individual characteristics are exerting a greater influence in Deck than in other divisions.

Along this line, Kleinman (4) studied personnel factors associated with maintenance-related naval aviation accidents and found that older ( $\geq 21$  years),

more experienced ( $\geq$  E-4), and better educated ( $\geq$  12 years) workers were less likely to be involved in injury-producing mishaps than were their younger, less experienced, and more poorly educated coworkers.

On the other hand, neither the Pugh nor the Gunderson studies included a direct assessment of the potential role of such individual factors. While these measures were assessed indirectly, characteristics such as age, pay grade, and education were not included. Thus, as noted by these authors, their studies may not have provided a fair assessment of the role of such individual measures.

Differences in personnel composition are not the only possible explanation, however. Recent developments in social systems approaches to health and personnel effectiveness have suggested several alternatives (5,6,7).

One such alternative, which has received considerable research attention in the past, is concerned with determining the influences of leader behavior (8). It seems reasonable to expect that for individuals working in either hazardous or potentially hazardous environments, leaders evaluated as uninvolved in task completion, untrustworthy or nonsupportive, and generally incapable of providing effective direction may contribute indirectly to increased injury rates (7).

Such reasoning suggested that it might be fruitful to explore more directly the degree to which perceived leadership style and personnel characteristics were related to accident and trauma rates in both Deck and Engineering Divisions.

Information about demographic composition as well as perceived leader behavior was obtained from 776 male enlisted personnel in the "B" (Boiler), "M" (Machinery), and Deck Divisions of 15 U.S. Navy combat ships. These ships included three destroyers, seven guided missile destroyers, three frigates, and two destroyer escorts.

Demographic measures consisted of age, training, education, and tenure.

The measures of perceived leader behavior (8) included:

- support (extent to which the leader is aware of and responsive to the needs of subordinates);
- goal emphasis (behavior that stimulates personal involvement in meeting group goals);
- work facilitation (behavior that helps to achieve goal attainment);
- interaction facilitation (behavior that encourages the development of close, mutually satisfying relationships within the group);

- planning and coordination (degree to which supervisors are able to plan and coordinate the group's abilities to achieve maximum performance);
- upward interaction (degree to which a supervisor is successful in interactions with higher levels of command);
- confidence and trust (group members' feelings of trust and confidence in their supervisors).

## FINDINGS

Two major relationships were expected and generally supported by the analyses.

First, individual difference measures indicated that significantly more job-related accidents and injuries were experienced by younger, less educated, and inexperienced workers, regardless of division assignment. These characteristics were more common in Deck than in Engineering Divisions.

Second, perceived leader behaviors were related to accident and injury rate, over and above the influences found for personnel composition among Deck Division workers. At the same time, leader behaviors were not related to injury rates for "M" and "B" Division personnel. A more detailed discussion of these findings has been presented elsewhere (9).

These results suggested that complex interrelationships exist among individual, environmental, and organizational variables. In hazardous environments, for example, little influence is felt from either individual or organizational factors, since environmental conditions regarding area safety are so pervasive. Thus, it appears that accident prevention in Engineering spaces may be accomplished more effectively by emphasizing greater environmental (i.e., equipment) protection, safety programs, etc.

On the other hand, the critical variable in work situations such as Deck Maintenance appears to be leader effectiveness in planning and organizing activities while at the same time maximizing available equipment and manpower resources (10).

It is important for ship officers and petty officers in certain high-risk divisions to become cognizant of the interrelated nature of task requirements, personnel characteristics, and leadership styles in their daily interactions with men from their own and other divisions and departments. In either Deck or Engineering Divisions, these individual differences are important with regard to training and work experience. Thus, increased attention should be directed toward expanding the worker's ability to cope with the environmental or organizational factors predictive of trauma.



## SUMMARY

Efforts by the Naval Health Research Center, San Diego, to explore the contribution of selected environmental, organizational, and individual factors associated with work-related accidents are discussed.

This research has indicated that the strength of association between environmental or organizational variables and subsequent accident rates is dependent upon the degree of hazard in the job, personnel composition, and leader behaviors.

Finally, findings are discussed in terms of future programs directed toward increasing the worker's ability to recognize the most salient factors associated with work-related trauma.

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## Trichloroethylene Dangers

Trichloroethylene (TCE) is a clear, colorless liquid with the "sweet" odor characteristic of the chlorinated hydrocarbons. Usually it is used as a degreasing solvent by metal fabrication shops, and in the production of waxes, gums, and pesticides. Specific uses range in complexity from "bucket" operations, in which the solvent is used in small quantities to clean tools, to large mass-production degreasing operations provided with engineering controls.

Chemically, TCE is not dangerously reactive; however, it does slowly decompose when exposed to light and water vapor, forming hydrogen chloride gas and, at elevated temperatures, chlorine. Trichloroethylene may react with strong alkalis to form chloroacetylene and/or dichloroacetylene, which are very toxic and can be explosive. In addition, TCE may decompose on

contact with certain metals, with open flames, with ultraviolet radiation, and during many welding operations, and may form phosgene and/or hydrogen chloride. Because of the slight decomposition that is possible with pure TCE, commercial grades usually contain stabilizers or inhibitors.

TCE vapors can easily be controlled in systems that incorporate partial enclosure, temperature control of the vapors, and/or local exhaust ventilation. Whenever such controls are not effective, however—or when there is a need for open transfer of the liquid—the dangerous potential for overexposure of workers to this material exists.

Studies have indicated that TCE is absorbed rapidly by the lungs following inhalation and is eliminated to only a small degree on exhalation. The outstanding characteristics of TCE overexposure include

headache, dizziness, vertigo, tremors, and a feeling and appearance of light-headedness or drunkenness. These symptoms may progress to unconsciousness and, in some cases, death. Long-term illnesses include CNS depression, kidney and liver damage, and in some cases cardiovascular failure.

- A physical exam, including cardiac, pulmonary, liver, and kidney examinations, should be made available yearly for persons exposed to TCE. BUMEDINST 6260.22 lists guidelines for the examinations required.

- Handling and hazard-warning labels should be applied to TCE tanks or containers.

- If local exhaust ventilation is unavailable or is inadequate to remove TCE vapors, exposed workers must wear the approved NIOSH respirator (NSN 00-022-2524).

—Adapted from the Pacific Health Bulletin

# A Psychiatric Nursing Care Plan: Total Care for the Patient in Military Psychiatry

LCDR Diane K. Hoblitzell, NC, USNR

Planning total nursing care for the hospitalized patient is a central part of every nurse's education, but care of the psychiatric patient presents unique problems. Yet all too frequently, in facilities where psychiatry is only a small part of the services offered by the hospital, nursing personnel may try to adapt the standard nursing care plan used in medical-surgical areas for use with psychiatric patients. As a result, crucial problems may often be missed; communication among staff members about the patient's needs is inadequate; corrective action for specific problems is not carried out; and a consistent therapeutic milieu is not established.

In such circumstances, all that has been accomplished is to temporarily remove the patient from the stresses he came from and put him in another environment. If we do not provide positive growth experiences for the patient and help him identify his problems and find better ways of dealing with them, we have failed in treatment.

## DEVELOPING THE PLAN

At NRMJ Jacksonville, the nursing staff devised a two-part psychiatric nursing care plan designed to ensure a consistent therapeutic milieu and a highly individualized treatment program.

Part I of the plan (Figure 1) deals with the general nursing treatment of the psychiatric patient, including attitudes with which he or she is to be approached, and appropriate therapies. It includes a number of patient-information items that are common to all nursing care plans, but deletes items that seldom, if ever, affect the psychiatric patient. In place of these,

LCDR Hoblitzell was charge nurse of the Psychiatric Unit at Naval Regional Medical Center Jacksonville, Fla., from January 1976 to December 1977. She is currently on inactive status.

the form provides additional space, under "special instructions," where special-care requirements can be emphasized.

The following items in Plan I are specific to care of psychiatric patients and require brief explanation.

**Special precautions.** On admission, and periodically throughout the hospitalization period, each patient is evaluated by both the psychiatrist and the nursing staff as to suicide, "elopement" (escape), or other precautions required. This section of the nursing care plan enables staff members to see at a glance what degree of observation the patient requires at any point in his hospital stay.

- "Suicide I" classification is ordered for all patients considered high suicide risks. Precautions include the following:

1. The patient will be in a restricted status on the ward.

2. The patient will be under *constant* 24-hour observation, on the ward and in all scheduled activities, by ward Hospital Corps personnel. (This includes observation while the patient is shaving or using head facilities, and throughout the night.)

3. Any seclusive or unusual behavior, or any attempts at self-harm, will be reported to the patient's doctor immediately.

- "Suicide II" classification is ordered for patients considered to be lesser suicide risks. Precautions 1 and 3 above apply, but the patient is under *close*, rather than *constant*, observation on the ward and in scheduled activities. (This includes observation of the patient while he is shaving and at 30-minute intervals around the clock.)

- "Elopement" or other precautions required for individual patients should be ordered as indicated and noted on the nursing care plan.

**Privileges.** The patient's privilege status is a major indication of his progress and ability to cope



with increasing responsibilities. At NRMJ Jacksonville, the progression of privileges is as follows:

- **Restricted status (ward privileges).** During the initial evaluation period, each patient must remain on the ward in pajamas and robe. The patient participates in all scheduled activities off the ward (e.g., occupational and recreational therapy) and keeps appointments in other areas of the hospital with a staff escort. He is not allowed visiting or telephone privileges, and he eats on the ward.
- **Hospital privileges.** The patient may go to any area of the hospital building that is open to visitors and other patients. He must wear the uniform of the day—on or off the ward—from 0800 to 1600, after which appropriate civilian dress is acceptable. He may have telephone, visiting, and Red Cross privileges as desired, and must eat in the mess hall. He must sign in and out in the ward log, indicating his exact location at all times; return to the ward for prescribed medications and all scheduled activities; and be on the ward for the night by 2200.
- **Base privileges.** The patient has the same privileges and responsibilities as with hospital-privilege status, except that he is also free to go to any unrestricted areas on the base.
- **Class II liberty.** The patient may leave the base for overnight on Wednesdays and weekends.
- **Class I liberty.** The patient may leave the base at 1600 each day for overnight.

Liberty-status patients have the same responsibilities regarding hospital and ward routine as those with hospital or base privileges. They must remain near the ward during the day, but are given special consideration when they need to take care of personal matters—particularly if these are related to discharge planning and future goals. Liberty-status patients are also responsible for getting prescriptions for liberty medications filled and for taking their medications as prescribed.

Once the patient has reached a Class I liberty status and has demonstrated ability to handle responsibilities and cope with the realities of everyday living, he should be ready and able to accept discharge from the hospital setting.

**Therapies.** Psychiatric patients improve more rapidly when their time is occupied: they should not be ignored or allowed to remain idle. Many of these patients have low self-esteem and lack the initiative and/or confidence that would prompt them to seek activity spontaneously. Therefore, the nursing staff endeavors to create a program of therapeutic value that will fill the patient's time.

At NRMJ Jacksonville, therapies offered include

occupational, recreational, group, and individual therapy, as well as a work program. Each patient participates in all of these at some point during hospitalization. The nursing staff must be aware of the patient's progress in these therapies and be alert to needs for more encouragement or for individualized attention.

The nursing care plan clearly outlines for all staff members the types of therapy in which the patient is involved. Notations on specific areas of emphasis can further enhance a consistent team approach.

**Milieu therapy.** Perhaps the most important element in providing a therapeutic milieu is a consistent approach to the individual patient. It is confusing to the patient when one staff member is overly solicitous while another shows little attention, or when one adheres strictly to ward policies while another interprets them loosely and gives the patient a great deal of personal leeway. Planning the approach to which the patient will respond most favorably is crucial in managing the overall hospital experience.

The concept of "attitude therapy" was developed at the Menninger Hospital in Topeka, Kan., and has proved highly successful. At NRMJ Jacksonville, the nursing staff has defined five different approaches for attitude therapy. The approach to be used for a particular patient is ordered by the psychiatrist and adhered to by all members of the nursing team. As the patient's needs change, the attitude prescription may also change.

- "Active friendliness" is the attitude most frequently used with inhibited or withdrawn, schizophrenic or psychotic patients. This prescription requires that the nursing staff take the initiative in demonstrating caring, concern, and special interest in the patient. The quality and quantity of attention given to any patient at a particular time must be within therapeutic boundaries, but the nursing staff should always be ready to assist him, be aware of his whereabouts, and attempt to minimize withdrawal.

- "Passive friendliness" is most often used with patients with paranoid personalities or problems. This prescription calls for the nursing staff to maintain a "psychological distance," letting the patient take the initiative in building a relationship, and responding to him in a therapeutic, friendly manner. Staff should not force attention on the patient, but brief contacts should clearly give the message that staff members are available to help when needed.

Common courtesy and compliance with ward routine should be expected of these patients.

- The "matter of fact" attitude is prescribed primarily for patients with personality disorders—for



[illegible]

FIGURE 2: The plan—Part II.

example, narcissistic or manipulative patients. Nursing staff should not take the initiative or get personally involved with these patients. They should maintain a casual, unemotional approach, without showing lack of interest. Direct reassurance should be avoided.

- “Kind firmness” is the attitude prescribed for depressed patients. Nursing staff should direct their resources toward getting the patient to express anger. They should not sympathize, overencourage, or be swayed by the patient’s complaints but, rather, always imply hope. The staff should convey a feeling of assurance that they know what is to be done. Staff should not challenge or be overbearing.

Expectations of the patient should be stated directly, clearly, and with quiet confidence, and the staff should make sure that the patient follows through. The doctor's order for this attitude should specify whether physical constraint is to be used in implementing it.

- “Reality encouragement” is the attitude often prescribed for confused patients. This is a nonjudgmental approach: the nursing staff does not interpret, but simply points out reality to the patient—including attention to such basic physical needs as eating, elimination, etc.

Specifying the prescribed attitude approach on the nursing care plan eliminates guesswork by staff, gaps in communication, and inconsistency of treatment. It is, of course, crucial that all staff members fully understand the definitions and concepts behind the attitude prescriptions, and the methods by which they should be implemented.

The nursing staff must be involved in the continuing evaluation of prescribed approaches and should have a voice in recommendations for any needed changes.

## THE PLAN—PART II

We have been discussing general nursing treatment of psychiatric patients; however, these patients may exhibit a variety of individual problems that nursing staff should recognize and work with. Part II of the Psychiatric Nursing Care Plan (Figure 2) was developed with this in mind.

The section of Part II on problems, goals, and approaches should be started after initial evaluation of the patient for four or five days following admission. In this section, the nursing staff should clearly identify individual problems that come to light. For example, the patient may be having trouble with eat-

ing, sleeping, or elimination. He or she may be actively hallucinating or delusional. There may be problems with low self-esteem, or difficulties in interpersonal relationships. Family problems may impede the patient's progress and need to be dealt with, etc.

For each area of difficulty identified, the staff must establish goals to work toward; then develop practical approaches for reaching them. Indeed, this problem-solving effort is the area of greatest challenge in psychiatric nursing care: the area where the staff focuses its resources to work for the rehabilitation of the patient.

Notations in this section of the nursing care plan must be concise and specific: the various members of the nursing team, changing from shift to shift, must be able to look at the plan for a particular patient and know what areas to concentrate on. Once a problem has been eliminated or a goal attained, Part II should be dated in the appropriate column and substantiation provided in the nursing notes for that date.

The second section of Part II involves planning for the patient's discharge.

From the first day of the patient's hospitalization, the nursing staff should have in mind the objectives to be met prior to discharge. These objectives, as stated in the nursing care plan, should outline what the staff expects to accomplish with and for the patient during the hospitalization period. They should include the patient's better understanding of his illness, understanding of any medications to be taken

after discharge, and demonstration of better coping mechanisms in specific problem areas.

The discharge objectives are an essential part of the nursing audit, and documentation that they have been reached must be retrievable in designated areas of the patient's chart. More importantly, though, a clear statement of the discharge objectives, made at the start of the patient's hospitalization, gives the nursing team a rehabilitative focus to work toward throughout his stay.

## SUMMARY

The psychiatric patient presents specific problems and needs, requiring a special type of treatment by trained individuals. Unless nursing care during hospitalization is carefully planned, no more will have been accomplished for the patient than to temporarily remove him from the stressful situation that precipitated his hospital stay.

Psychiatric hospitalization itself is stressful; however, a carefully controlled environment, appropriate therapies, a consistent approach, effective problem solving, and thorough discharge planning will provide maximum benefits to the patient from his hospital stay—and shorten its duration.

The Psychiatric Nursing Care Plan, Parts I and II, provides both an invaluable form of communication among staff members and a total nursing treatment plan directed toward a successful outcome for the hospitalized psychiatric patient.

## Notes from the I.G., Medical

Following are some common problems identified during recent command inspections:

- **JCAH accreditation.** Cardiopulmonary resuscitative training of physicians, nurses, and allied health personnel in the Emergency Services area is required and should be documented.

- **Loss awareness program.** The national average of losses in civilian hospitals from all causes (theft, fire, lost time, etc.) has been estimated at \$1,400 per bed per year. If this figure is accurate, the Navy health care system is suffering losses in excess of \$16 million per year. Everyone involved in health care must be aware of loss and protect

diminishing dollar resources.

- **Policy/procedural manuals.** A written policy/procedural manual is to be available in all patient care areas of branch clinics and naval regional medical centers to guide personnel in performance of duties. Specific infection control and safety policies are to be incorporated, and the manuals should be dated to indicate the time of formulation, review, or revision.

- **Medical records.** Authentication of entries in medical records must be dated and must identify the individual as to Corps or civilian title.

Emergency records must include the condition of the patient on release and instructions to the pa-

tient/parent regarding medication and when or under what circumstances to return for followup.

Personnel authorized to accept and transcribe verbal orders must be identified in medical staff by-laws or rules and regulations. Moreover, the medical staff should define those verbal orders that must be authenticated by the responsible medical officer within 24 hours.

Discharge summaries must include information relative to the condition of the patient upon discharge, medication, any special diet, level of activity that may be performed, and when to return for followup care.

—Roger F. Milnes, RADM, MC, USN

# BUMED SITREP

**WANTED: EPIDEMIOLOGIST . . .** The Occupational and Preventive Medicine Division of BUMED is seeking a primary-care medical officer for assignment as epidemiologist to Navy Environmental and Preventive Medicine Unit No. 7, Naples, Italy. The candidate would be trained on the job by the officer in charge, who is board certified in preventive medicine and is an experienced epidemiologist, and by the unit's allied science professionals. The position involves considerable travel in Europe and the Mediterranean area and will be open in the summer of 1978. Following this tour, interested physicians would be encouraged to enter an M.P.H. program and training for board certification in a preventive medicine specialty. Interested officers should write or call CAPT D.F. Hoefler (MC), Director of Occupational and Preventive Medicine at the Bureau of Medicine and Surgery (Code 55); Autovon 294-4620 or Commercial (202) 254-4620.

**WORKSHOP SCHEDULED . . .** The Naval Health Sciences Education and Training Command (HSETC) will host an operational medicine workshop 12-15 June 1978 at the Holiday Inn, Embarcadero, San Diego, Calif. Purposes of the workshop are to review the present state of operational medicine training and practice, identify specific deficiencies and problems, and recommend steps to overcome them; recommend a general system of operational medicine training; recommend a pathway for career training in operational medicine; and partially formulate curriculum outlines for selected operational medicine training programs.

Findings and recommendations of workshop participants will be consolidated by HSETC and later made available on request.

**MAXILLOFACIAL CASUALTIES . . .** Navy Dental Corps researchers have been collecting data on long-term results of maxillofacial casualty treatment since 1968. Emphasis has been on evaluating reconstructive and rehabilitative procedures to determine the effectiveness of cosmetic and functional results. A textbook, *Management of War Injuries to the Jaws and Related Structures*, based upon data from this study,

is to be published this year. Collaborative studies are being developed with the National Academy of Sciences medical followup agency and the Veterans Administration to investigate the psychological impact of oral-facial injury and treatment.

**DENTAL METALS STUDIED . . .** Navy investigators at the National Bureau of Standards, Gaithersburg, Md., are working to resolve problems associated with various dental restorations that require casting metal into molds. Non-precious and semiprecious metals that could replace costly gold are being studied. If these metals prove to be the equivalent of gold in fitting and wear characteristics, and if they are shown to have the same biological acceptance, they could help Navy dentists to provide their patients with high-quality, low-cost crown and bridge prostheses.

**OPERATIONAL MEDICINE DEPT . . .** The Naval Health Sciences Education and Training Command has established a Department of Operational Medicine, with CAPT Bythel D. Dutton (MC) as first director.

The primary objective of the new department is to develop, manage, execute, and administer general and categorical operational medicine programs. Specific goals are:

- To develop and execute requirements-based education and training programs.
- To provide Medical Department personnel with the technical, scientific, and managerial skills and knowledge which they need to perform in operational medicine billets.

**WARNING . . .** Recent information from the Office of the Surgeon General of the Air Force defines a possible problem, involving "composite fiber phenomenon," that may be encountered by medical personnel involved in the investigation of aircraft mishaps of certain types.

Composite fibers are strands of carbon- or boron-coated tungsten that typically are imbedded in an epoxy matrix to produce a material of superior structural properties, where high strength and light weight are important. When this material is burned or im-

pacted, the fibers may become airborne. If they achieve contact with electrical components of power stations, generators, computers, etc., they can cause arcing, electrical short circuits, and systems failures. Accordingly, a warning is directed to personnel responding to any accident scene involving aircraft with composite structural members. Inhalation, contact, or other health hazards do not appear to be significant because of the predominantly large particle size involved.

The unclassified code name "CORKER" is used to denote mishaps involving aircraft in which composite fibers are a part of the aircraft structure.

**NEW PATHOLOGIC DEFECT . . .** A previously unrecognized pathologic defect has been discovered by investigators at the Armed Forces Institute of Pathology. The disease—myo-adenylate deaminase deficiency—was discovered following development of a new histo-enzymatic stain by Dr. William N. Fishbein, chief of the AFIP Biochemistry Division.

The stain has been applied to all frozen muscle biopsies received at AFIP, with myo-adenylate deaminase deficiency identified in six specimens. The patients have a history, often since childhood, of muscle weakness or cramping after exercise. Muscle biopsy shows minimal or no pathologic changes other than absence of the enzyme. All cases were verified by solution assay of muscle biopsy homogenates.

AFIP researchers believe the disease is fairly common and may account for a large percentage of patients previously diagnosed as having benign congenital hypotonia or nonprogressive congenital myopathy. The diagnosis of myo-adenylate deaminase deficiency may have been missed in the past because patients' muscle histology and red cell enzyme level were normal. A description of the disease and its implications for muscle physiology will be published shortly in the journal *Science*.

AFIP can carry out a full battery of histo-enzymatic stains, fiber type and size histograms, and solution assays. The Institute invites physicians to submit muscle biopsies for any patients suspected of having myo-adenylate deaminase deficiency.

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